BMJ

LONDON, SATURDAY 30 OCTOBER 1993

Socioeconomic differentials in wealth and health

Widening inequalities in health—the legacy of the Thatcher years

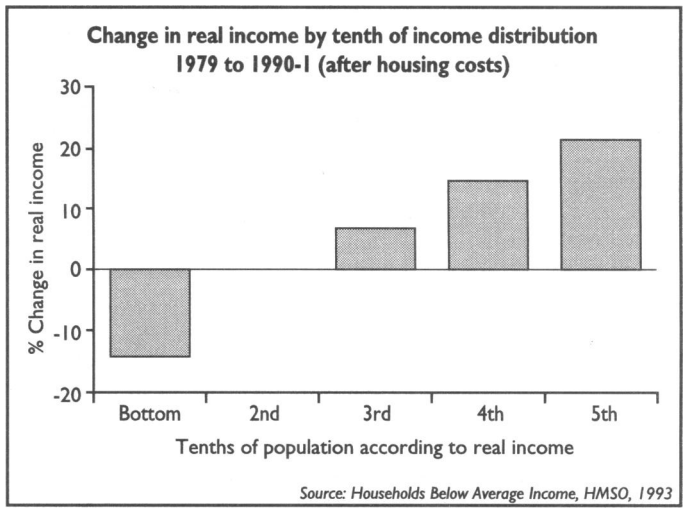
Is it not a mis-reading of the social structure of this country to dwell on class divisions, when, in respect of dress, speech, and use of leisure, all members of the community are obviously coming to resemble one another? (1937)[1]

The classless society anticipated by Mr Major has had an extended gestation, which shows no sign of ending. Statistics showing the association between poorer material circumstances and higher mortality, of the kind provided by Eames and colleagues (p 1097),[2] have long served to correct the notion that the importance of social class is decreasing. The repetition of such well supported findings may be especially useful at a time when the issue of inequalities in health is being sidelined. For conservative social commentators such sidelining is a component of general propagandising against equitable redistribution of income[3] for increasingly marginalised public health doctors the issue is simply going by default.[4]

Paradoxically, the ubiquitous and persistent nature of socioeconomic differentials in mortality can reduce their salience. If inequalities in health have always been with us and are present in every industrialised country is it realistic to make their reduction a goal of health policy? This seemed to be the reasoning behind the exclusion of such a target from the strategy outlined in *The Health of the Nation*.[5] The extent of the differentials, however, can be shown to vary both temporally[6,7] and geographically,[8] indicating that a reduction in these inequalities is achievable.

Trends in the size of socioeconomic differentials in mortality over time mimic those of inequalities in income: between 1921 and 1981 widening disparities in the distribution of income were accompanied by increasing mortality differentials and vice versa.[7] Such analyses have relied on the publication of mortality specific to each social class around each decennial census; figures for 1991 should become available in three to four years' time. Meanwhile, evidence is emerging that increasing mortality differentials have accompanied the social polarisation of the Thatcher years.

Phillimore *et al*, who previously showed a strong association between deprivation and mortality at the area level in the northern region of England for the early 1980s,[8,9] have shown that between 1981 and 1991 there were appreciable increases in mortality differentials between the most deprived and least deprived electoral wards (P Phillimore and A Beattie, northern region epidemiology group annual conference, Newcastle upon Tyne, 7 July 1993). This is largely the consequence of deterioration in the experience of the most deprived areas relative to that of the rest of England and Wales. Similarly, in Glasgow the mortality differential between affluent and deprived neighbourhoods grew between 1981 and 1989. Over the same period Glasgow, which contains 80% of the most deprived postcode sectors in Scotland, has shown a worsening of mortality relative to that in the rest of Scotland.[10]



Paralleling these trends in mortality differentials, redistributive social policies resulted in increasing disparities in wealth and material wellbeing. While the richest 10% of the population gained £87 a week from tax cuts and shifts from direct to indirect taxation, the poorest 10% lost £1 a week.[11] The result of this has been a fall in real income for the already worst off members of society. After housing costs were taken into account, the group receiving the lowest 10% of income suffered a 14% loss between 1979 and 1990-1 while higher earning groups benefited to an increasing degree (figure),[12] Inequalities in income have consequently grown dramatically: only 9% of the population was living on less than 50% of the average income in 1979, a proportion that had jumped to 24% by 1990-3.[12]

In the United States inequalities in income have increased since the early 1970s, a trend reinforced in the 1980s by the introduction of similar economic policies to those of Britain: cutbacks in welfare benefits and change in tax policy.[13] Although difficult to date accurately, mortality differentials seem to have increased in parallel with this.[14,15] In the United

States differences in the life expectancy of white and black people have also recently increased,[16] in concert with widening differentials in their incomes.[17]

The limited data that exist on cross national comparisons of inequalities in income and inequalities in health suggest that the two covary.[18] Furthermore, both cross sectional and time series analyses indicate that, for a given overall prosperity, countries with smaller differentials in income experience lower infant mortality and higher life expectancy.[19 20] Inequitable distribution of wealth may, therefore, be detrimental to the overall health profile of a country, not just to the health of an increasingly poor and disenfranchised minority.

If this is the case it is surprising that *The Health of the Nation* paid such scant attention to socioeconomic differentials—or "variations" (in its terminology)—in health. These variations are seen to result from "the complex interplay of genetic, biological, social, environmental, cultural and behavioural factors."[21] This perceived complexity seems to be used to justify the lack of activity aimed at reducing inequalities. As Eames and colleagues point out, their research "does not prove that the association between deprivation and mortality is causal."[2] Indeed, attempting to explain inequalities in any simple sense may be futile, while the concept of "cause" used in its usual epidemiological sense is probably inadequate.

This should not, however, blind us to some simple regularities. Increasing inequalities in mortality have occurred against a backdrop of large temporal and geographical variations in mortality. Differences in degree of material wellbeing can account for mortality differentials between poor and rich countries; for general reductions in mortality over long periods, as happened in Britain over the past 150 years; as well as for mortality differentials, and trends in these differentials, within countries. When some commentators attempt to reduce higher death rates among manual classes to "cultural patterns of behaviour" such as smoking and diet, they seem to lose sight of this fact. Inequalities in health were considerable at a time when, if anything, it was better off people who smoked more, consumed a higher fat diet, and engaged in little physical activity. Any increasing social polarisation of such activities may exacerbate the gradients of health differentials; they are not, however, their root cause.

Exactly those groups who have been subjected to cuts in—or reduced access to—benefits, to casualisation of work, to unemployment, and to changing tax policy, have now been taken to task for their predicament. At the Conservative party's recent conference it was easy to get the impression that lone mothers—the group that has fared worst economically since 1979—have replaced the (rapidly disappearing) miners as the enemy within. This sits uneasily with Mr Major's vision of a classless society, brought about by social mobility and "the capacity of everyone to have the help necessary to achieve the maximum for their ability."[22] With regard to allowing everyone the opportunity of achieving the maximum health—the "be all you can be" so beloved of health promoters—a reversal in the dramatic upwards redistribution in wealth is what is required.

GEORGE DAVEY SMITH
Senior lecturer in epidemiology and public health
Department of Public Health,
University of Glasgow,
Glasgow G12 8RZ

MATTHIAS EGGER
Senior research fellow
Department of Social and Preventive Medicine,
University of Berne,
CH-3012 Berne,
Switzerland

1 Carr-Saunders AM, Caradog Jones D. *A survey of the social structure of England and Wales.* Oxford: Clarendon Press, 1937.
2 Eames M, Ben-Shlomo Y, Marmot MG. Social deprivation and preventive mortality: regional comparison across England. *BMJ* 1993;**307**:1097-102.
3 Le Fanu J. *A phantom carnage. The myth that low income kills.* London: Social Affairs Unit, 1993.
4 Salter B. Public image limited. *Health Services Journal* 1991;**103**:28-9.
5 Department of Health. *The health of the nation: a consultative document for health in England.* London: HMSO, 1991.
6 Pamuk ER. Social class inequality in mortality from 1921 to 1972 in England and Wales. *Population Studies* 1985;**39**:17-31.
7 Wilkinson RG. Class mortality differentials, income distribution and trends in poverty 1921-1981. *Journal of Social Policy* 1989;**18**:307-35.
8 Lahelma E, Valkonen T. Health and social inequalities in Finland and elsewhere. *Soc Sci Med* 1990;**31**:257-65.
9 Townsend P, Phillimore P, Beattie A. *Health and deprivation: inequality and the north.* London: Croom Helm, 1988.
10 Forwell GD, *Glasgow's health: old problems—new opportunities. A report by the director of public health.* Glasgow: Department of Public Health, 1993.
11 Oppenheim C. *Poverty: the facts.* London: Child Poverty Action Group, 1993.
12 Department of Social Security. *Households below average income. A statistical analysis 1979-1990/91.* London: HMSO, 1993.
13 Plotnick RD. Changes in poverty, income inequality, and the standard of living in the United States during the Reagan years. *Int J Health Serv* 1993;**23**:347-58.
14 Feldman JJ, Makuc DM, Kleinman JC, Cornoni-Huntley J. National trends in educational differences in mortality. *Am J Epidemiol* 1989;**129**:919-33.
15 Pappas G, Queen S, Hadden W, Fisher G. The increasing disparity in mortality between socioeconomic groups in the US, 1960-1986. *N Engl J Med* 1993;**329**:103-9.
16 Rogers RG. Living and dying in the USA: sociodemographic determinants of death among blacks and whites. *Demography* 1992;**29**:287-303.
17 Hacker A. *Two nations: black and white, separate, hostile, unequal.* New York: Ballantine, 1992.
18 Davey Smith G, Bartley M, Blane D. The Black report on socioeconomic inequalities in health 10 years on. *BMJ* 1990;**301**:373-7.
19 Wilkinson RG. Income distribution and life expectancy. *BMJ* 1992;**304**:165-8.
20 Wennemo I. Infant mortality, public policy and inequality—a comparison of 18 industrialised countries 1950-85. *Sociology of Health and Illness* 1993;**15**:429-46.
21 Department of Health. *The health of the nation: a strategy for health in England.* London: HMSO, 1992.
22 Edgell S. *Class.* London: Routledge, 1993.

Childhood drownings: who is responsible?

Governments should act

"Where were you when your child drowned?" the mother of a drowned child was asked at a public forum in Sydney last year after she had spoken in favour of legislation making fencing around swimming pools compulsory. This exchange illustrates the polarised nature of the debate over child safety: is it solely parents' responsibility to keep their children safe or does a government have a right, or indeed an obligation, to require certain safety standards in the community? This dilemma is not confined to drowning in swimming pools but encompasses many issues concerning the safety of children and adults.

Drowning is an important cause of death in childhood in developed countries such as Australia, New Zealand, the United States, Canada, and Britain; in some countries it is the main cause of death between the ages of 1 and 4.[1-4] For every death from drowning there are an estimated six to 10 cases of near drowning requiring admission to hospital. Between 5% and 20% of these children will suffer neurological sequelae.[5 6] Children drown at various sites, including swimming pools, rivers, creeks, dams, and the sea, and in baths and buckets. The leading site of drowning in young children is domestic swimming pools, with natural areas of water assuming more importance as age increases. Although different sites of drowning offer a range of preventive opportunities, some common principles can be identified.

Risk factors for childhood drowning can be divided into three categories relating to the child, parental, and environ-